Pam Nelson, DNP, PMHNP-BC, FNP-BC
2300 21st Avenue South, Suite 101
Nashville, TN 37212
Phone 615-807-0784

Patient Information:

Today's Date:_____

Last Name:_____ First Name: _____MI:_____

What do you prefer to be called? (if different from legal name):_____

Date of birth: _____ Age: _____ Sex assigned at birth: MALE / FEMALE

Social Security #: __ __ __ - __ __ - __ __ __ __

Phone number: _____

Email address: _____

Address: _____

City:_____ State: _____ Zip: _____

Who referred you? _____

Who is your primary care provider?_____

Spouse's Name (if applicable): _____

Spouse's Phone: _____

Patient's Employer/Occupation: _____

Emergency Contact: _____

How is the emergency contact related to you?_____

Emergency Contact's Phone: _____

Pharmacy:_____

Pharmacy Phone:_____

Pharmacy Address: _____

City: _____ ,Tennessee Zip:_____
Your pharmacy must be located in Tennessee.

Please briefly describe current symptoms for which you are seeking treatment today:

Psychiatric Hospitalizations (include where, when, and for what reason):

Have you ever had ECT? **No___** **Yes___**

Have you ever had psychotherapy? **No___** **Yes___**

Name of your previous psychiatrist(s) or psychiatric nurse practitioner(s)?

CURRENT MEDICATIONS	
Drug allergies? No__ Yes__ To What?	
Please list any medications you are taking now, including non-prescription medications & vitamins or supplements.	
Name of drug:	**Dose (include strength & number of pills per day):**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

PAST MEDICAL HISTORY

Do you now have or have you ever had any of the following conditions? (please put a check next to those that apply)

__Diabetes	__Heart murmur	__Crohn's disease
__High Blood Pressure	__Pneumonia	__Colitis
__High Cholesterol	__Pulmonary embolism	__Anemia
__Hypothyroidism	__Asthma	__Jaundice
__ Goiter	__Emphysema	__Hepatitis
__Cancer (type)_____	__Stroke	__Stomach or peptic ulcer
__Psoriasis	__Epilepsy (seizures)	__Rheumatic fever
__Angina	__Cataracts	__Tuberculosis
__Heart problems/arrhythmia	__Kidney disease	__HIV/AIDS
	__Kidney stones	

Other medical conditions/surgeries not listed here:

PERSONAL HISTORY

Were there problems with your birth/delivery? (specify)
Where were you born and raised?
What is your highest education?
Marital status?
What is your current or past occupation?
Are you currently working? __yes __no Hours per week?
If not, are you __retired __disabled __sick leave?
Do you receive disability or SSI? __yes __no If yes, for what disability and for how long?

Do you have any legal problems? (specify)

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
Family Member	Age	Psychiatric Illness	Age at Death	Cause of Death
Father				
Mother				
Siblings				
Children				

Extended Family Psychiatric Problems:

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
__Recent weight gain, how much?__
__Recent weight loss, how much?__
__Fatigue
__Weakness
__Fever
__Night sweats

MUSCLE/JOINTS/BONES
__Numbness
__Joint pain
__Muscle weakness
__Joint swelling

EARS
__Ringing in ears
__Loss of hearing

EYES
__Pain
__Redness
__Loss of vision
__Double or blurred vision
__Dryness

THROAT
__Frequent sore throat
__Hoarseness
__Difficulty in swallowing
__Pain in jaw

HEART AND LUNGS
__Chest pain
__Palpitations
__Shortness of breath
__Fainting
__Swollen legs or feet
__Cough

NERVOUS SYSTEM
__Headaches
__Dizziness
__Fainting/loss of consciousness
__Numbness or tingling
__Memory loss

STOMACH AND INTESTINES
__Nausea
__Heartburn
__Stomach pain
__Vomiting
__Yellow jaundice
__Increasing constipation
__Persistent diarrhea
__Blood in stool
__Black, tarry stool

SKIN
__Redness
__Rash
__Nodules/bumps
__Hair loss
__Color changes of hands/feet

BLOOD
__Anemia
__Clots

KIDNEY/URINE/BLADDER
__Frequent or painful urination
__Blood in urine

WOMEN ONLY
__Abnormal Pap Smear
__Irregular menses/periods
__Bleeding between periods
__PMS

PSYCHIATRIC
__Depression
__Excessive worries
__Difficulty falling asleep
__Difficulty staying asleep
__Difficulties with sexual arousal
__Poor appetite
__Food cravings
__Frequent crying
__Sensitivity
__Thoughts of suicide or attempts
__Stress
__Irritability
__Poor concentration
__Racing thoughts
__Hallucinations
__Rapid speech
__Guilty thoughts
__Paranoia
__Mood swings
__Anxiety
__Risky behavior

OTHER PROBLEMS:

SUBSTANCE USE

DRUG CATEGORY	**Age when you first used?**	***How much & how often did you/do you use this?**	**How many years did you/have you used this?**	**When did you last use this?**	***Do you currently use this, and if yes, how much and how often?**
Alcohol					**__Y __N**
Cannabis: Marijuana, hash					**__Y __N**
Stimulants: Cocaine, crack					**__Y __N**
Stimulants: Methamphetamine- speed, ice, crank					**__Y __N**
Amphetamines/other stimulants: Ritalin, Benzedrine, Dexedrine					**__Y __N**
Benzodiazepines/tranquilizers: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					**__Y __N**
Sedatives/Hypnotics/Barbiturates: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					**__Y __N**
Heroin					**__Y __N**
Street or Illicit Methadone					**__Y __N**
Other Opioids: Tylenol #2 & #3, 282's, 292's, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					**__Y __N**
Hallucinogens: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					**__Y __N**
Inhalants: glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					**__Y __N**
Other: (specify)					**__Y __N**

Policies

Payment Policy:

Payment is required in full at the time of service. Credit cards/debit cards/Venmo, and cash payments are accepted. Please note that we do not keep cash at the office to make change for cash payments. A credit card is required to be placed on file in order to schedule and hold your appointments. We do not accept checks. Fees are as follows:

- New Patient Initial Consultation- (90 minutes or longer) $325
- Follow-up Visit- (25-30 minutes for medication management) $175
- Follow-up Visit- (55-60 minutes for medication management and addition time for therapy) $300
- Paperwork- There is a charge for any paperwork that the patient requests to have completed. Paperwork is completed only outside of appointments, and generally will incur a fee of $150-200, which is calculated dependent on time required to complete the forms.
- "No Show" or Late Cancellation Fees are as follows:

You will be charged in full for the cost of the service that was scheduled for "no-show" or late-cancellations of less than 48 hours, per office policy. If you do not come to your appointment, or if you are more than 10 minutes late to your appointment, it will be considered a "no show", and you will be charged for the service that was scheduled, and that appointment will need to be rescheduled. Appointments for which you arrive less than 10 minutes late will need to be shortened, and will need to end at the scheduled time, in order to accommodate the next patient's scheduled appointment start time. Please be on time for your appointments.

If you need to change or re-schedule an appointment, please call as soon as you can so we can accommodate you with a new appointment, as well as other patients who may wish to be seen during the appointment that you wish to cancel. Please leave a message (you may text or leave a voice mail 48 hours prior to your appointment) to cancel your appointment in order to avoid the late cancelation fee. You may leave the message to cancel your appointment on the weekend 48 hours prior to your Monday appointment in order to avoid the late fee. If you call to cancel and it is less than 48 hours, we may have someone else on a waiting list that can take your appointment time. If that is the case, we can give them your appointment time, and you can avoid a late cancellation fee, so it is much better to call and cancel than to "no show".

Policies, continued

Credit/Debit Card Authorization Form:

A credit card is required to be placed on file in order to schedule and hold your appointments. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

I/we authorize Nelson Psychiatric Associates PLLC to bill the credit/debit card for payments for services. I understand that my information will be saved to file for future transactions on my account. I will notify Nelson Psychiatric Associates PLLC in writing if I no longer want this credit/debit card billed or kept on file. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees, and will be billed accordingly.

PLEASE COMPLETE ALL FIELDS.

Patient's Signature:_____ **Date:**_____

Credit Card Information:

_____Visa _____ Master Card _____ Discover _____American Express

Card Number:_____

Expiration Date:_____

Security Code:_____

Billing Zip Code:_____

Name on Card:_____

Email Address for Card Holder: _____

Policies, continued

Insurance Policy:
As an out of network provider, Dr. Nelson is not contracted with any insurance companies, and does not accept any payment from insurance companies. If she is listed with your insurance company, that is for her inpatient hospital work and not for her outpatient office work. As a courtesy, a receipt, or superbill, can be provided to you, and you can file that with your insurance provider. Each insurance company has specific internal regulations and it is the patient's responsibility to determine if reimbursement can be made to him/her directly. Due to federal and state regulations, we are unable to accept patients into the practice who have insurance with Medicare, TennCare, Medicaid, or QMB insurance, even if you are willing to self-pay.

Office Hours:
Office hours are by appointment only, Monday through Thursday. We are closed on all federal holidays. We do not provide any emergency or after-hours services, and any phone messages left after 4 PM may not be returned until the next business day. **There is no answering service available. In the event of an emergency, please call 911, have someone drive you to the emergency department, call the Tennessee Statewide Mental Health Crisis Line at 855-274-7471 (855-CRISIS-1), text JASON to 741741, call the National Suicide and Crisis Lifeline at 988, call the National Suicide Prevention Lifeline at 800-273-8255 (800-273-TALK), or call the Community Assistance Program at 615-342-1450**. Some additional mental health and crisis resources that are available in Tennessee can also be found on The Jason Foundation website at the following link: https://www.tennesseewontbesilent.com/wp-content/uploads/2021/08/Tennesseee-Mental-Health-and-Crisis-Resources119308192021102341.pdf

Medication Refill Policy:
Medications are refilled during your appointment, and you will be provided with refills to last until your next appointment. **Call your pharmacy to ask about the status of your refills before calling the office. Do not call the office and ask for us to call your pharmacy and check on your prescription if you have not done this already.** If you need to change your appointment and are going to be out of your medication prior to your next appointment, be sure to call well in advance of your last pill. Medication refill requests require at least a 24-hour notice, and cannot be addressed on Friday, Saturday, Sunday, or holidays. After hours and weekend refill requests will not be called in until the next business day. Please call with your prescription drug information, including the drug name and dosage, as well as your pharmacy name, location, and their phone number, and **be sure to leave your first and last name, along with your date of birth and phone number when leaving any message**.

Services Provided:
Nelson Psychiatric Services, PLLC treats adults with Mood Disorders, Bipolar Disorder, Depression, ADHD, Social Anxiety, OCD, Panic Disorder, PTSD, Dual Diagnosis for persons who are sober and in recovery, among other diagnoses. We provide medication management focusing on the whole person, while taking into account how other medical conditions can affect your mental health, and will tailor your treatment to meet your needs and goals.

Services We Do Not Provide:
We are not best suited for those battling with active substance abuse and addiction who need inpatient detoxification. We very seldom prescribe benzodiazepines, and recommend avoiding their use if at all possible. On the rare occasion that a benzodiazepine might be prescribed, evidence-based medicine strongly advises that benzodiazepines are not prescribed for longer than two to four weeks, and this is the model that this practice follows. For more information on this topic, please visit https://www.benzoinfo.com/. We have

Policies, continued

separate controlled substance policies that patients are required to sign on the rare occasions that those medications are prescribed.

We do not treat sex offenders, nor do we provide any forensic services, or disability determinations. Nelson Psychiatric Associates, PLLC reserves the right to end any treatment relationship, with or without cause, in accordance with and as permitted by applicable ethical laws and guidelines.

Termination of treatment:
Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision to terminate care with your provider.

Policies, continued

Consent to treatment and patient financial responsibility:

Do you agree to be contacted via text regarding appointment reminders or changes? __Yes __No

If Yes, preferred mobile number: _____

Do you agree to be contacted via email? __Yes __No

If Yes, preferred email: _____

Confidentiality/Medical Records and Notice of Privacy Practices for Private Health Information to Individuals (HIPAA):

Patient privacy is essential and protected by law. Medical records will be maintained and are accessible by request. All protected health information will be stored via an electronic health record, which is HIPAA (Health Insurance Portability and Accountability Act) compliant. Protected health information will not be shared without your written consent unless required by the following three statutes:

- Any suspected child/elder abuse is required to be reported to the appropriate authorities.
- If there is reason to believe that the patient is an imminent danger to his/herself or to any other individual, we are required by law to report this to the appropriate authorities, as well as to warn the individual who may be threatened.
- When a patient is involved in legal proceedings, records may be subpoenaed.

In accordance with HIPAA, Nelson Psychiatric Associates PLLC provides the required notice of privacy practices to our service recipients. These are made available through our website www.nelsonpsychiatricassociates.com, and you may request a full printed copy of the notice of privacy practices from our office at any time. By signing this policy agreement form, you are stating that you aware that the HIPAA forms are available to you through the website and that you may also request a copy through the office.

I have read all of the policies listed, and I understand and agree to them. I agree to be treated by Dr. Pam Nelson, DNP, PMHNP-BC, FNP-BC, and when necessary, any doctors or nurse practitioners covering in her absence.

In addition, I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges for services rendered AT THE TIME OF SERVICES according to the office policies. I understand that unpaid balances over 30 days will be subject to a late fee. I understand that unpaid balances over 90 days are past due and may be referred to a collection agency.

Patient's signature:_____

Date:_____

Patient Email/Texting Informed Consent Information

1. **Risk of using email/texting**

The transmission of patient information by email/texting has a number of risks that one should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:

- Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Email and text sender can easily misaddress an email or text and send the information to an undesired recipient.
- Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect emails sent through their company systems.
- Emails and texts can be intercepted, altered, forwarded, or used without authorization or detection.
- Email and texts can be used as evidence in court.
- Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. **Conditions for the use of email and texts**

The provider cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. The provider is not liable for improper disclosure of confidential information that is not caused by his/her intentional misconduct. Patient or Legal Guardians must acknowledge and consent to the following conditions:

- Email and texting is not appropriate for urgent or emergency situations. The provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
- Email and texts should be concise. The patient/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
- All email will usually be printed off and filed into the patient's medical record. Texts may be printed and filed, as well.
- The provider will not forward patient's/legal guardian's identifiable emails and/or texts without the patient's/legal guardian's written consent, except as authorized by law.
- Patients/legal guardians should not use email or texts for communication of sensitive medical information.
- Physician is not liable for breaches of confidentiality caused by the patient or any third party.
- It is the patient's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. **Patient Acknowledgement and Agreement**

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me by email or text.

Patient Signature:_____ **Date:**_____

Interactions with CoCo: Informed Consent, Release, and Waiver

INTRODUCTION: CoCo is a geriatric Shih Tzu (breed of dog), who was rescued in December of 2023, and her history prior to that is unknown. She has since become a psychiatric support animal, who has been working in the office since March of 2023. She has very few teeth left, due to two oral surgeries that were required due to severe facial trauma from unknown causes that she had sustained prior to her rescue. Because of her breed and age, she does not shed, is very mild mannered, and sleeps most of the day.

RISKS AND BENEFITS: There are many benefits of having an animal present in the practice. Some benefits that have been found include:

- Animals help improve motivation and engagement in therapy.
- Animals provide a sense of security and emotional support. Dogs, specifically, offer unconditional acceptance and positive regard.
- Animals can promote relaxation. Research has demonstrated that petting an animal can help lower blood pressure, heart rate, and increase oxytocin (a feel-good chemical in the brain).
- Animals can help in the areas of focus and attention.
- Animals offer humor and fun due to their playful nature.
- Animals ask for patients to develop empathy, nurturance, and responsibility, and model other skills, like forgiveness and patience.

Even though there are many benefits to having relationships with animals, there are also risks involved. For example: dogs may nibble, accidentally scratch, lick, lean up against a client, and/or cause light bruising. These actions are not aggression, but rather are the dog's way of interacting with the client. In addition, if the patient is allergic to dogs or is unaware of an allergy, the client may suffer from an allergic reaction.

TERMINATION OF CARE: If the patient is allergic, has an unknown allergy to dogs that becomes a known allergy during therapy; if the patient exhibits problematic behavior toward CoCo, including but not limited to: kicking, biting, pushing, hitting, pulling the tail/ears/paws, and/or pinching CoCo; or if the patient has a fear of CoCo, and was not aware of a prior fear of animals existing, please be aware that we will identify that this is not be an ideal patient-provider relationship, and will need to terminate the session immediately. We will kindly refer you to a different provider, and a refill of medication will be supplied to bridge you to the next provider's appointment.

ALLERGIES: We cannot accommodate patients who have allergies to dogs. The client shall inform Dr. Nelson of any and all known environmental/food/and drug allergies. Please be aware that CoCo is usually at the office every day. Although you may not be directly interacting with CoCo, she will have been present in the office, and her dander remains in the area, and, as a result, there is no way to accommodate an allergy to dogs.

Interactions with CoCo: Informed Consent, Release, and Waiver, continued

ACCIDENTAL INCIDENTS: Although it is unlikely, if CoCo accidentally scratches, nibbles, or otherwise causes any harm to the patient, the patient agrees to notify Dr. Nelson immediately.

INTERACTIONS WITH CoCo: Dogs interact with humans differently than when humans interact with each other. Dogs wag their tails, lick people, may lean up against a person's leg, or lay near a human. This is how CoCo interacts with humans, although she does spend most of her day sleeping. If the client is uneasy or otherwise uncomfortable with how CoCo interacts with him/her, the patient agrees to express those concerns immediately to Dr. Nelson. If a patient prefers that CoCo be placed futher away from where they are sitting during sessions, please let Dr. Nelson know and she will put CoCo on the other side of the room, or will hold and contain her away from the patient.

CONDUCT TOWARD COCO: Just like a human being, CoCo should be treated with respect and kindness. If CoCo is sick or injured, she will not be at the office, and will obtain veterinary approval prior to returning to the office. Dr. Nelson is concerned for the general welfare and safety of the patients and of CoCo. If at any time CoCo becomes irritated, frightened, distressed, ill, or in any way exhibits any negative and/or aggressive behavior, Dr. Nelson may need to interact with CoCo to address the issue.

DISEASE: Every effort will be made to ensure against zoonotic disease transmission (i.e. the sharing of disease between humans and animals). CoCo will remain current on all standard vaccinations, such as rabies, as well as flea/tick preventative; however, there is always a risk of the transmission of a disease when interacting with animals. A client may request at any time to review a list of vaccinations that CoCo has received.

RELEASE AND WAIVER OF LIABILITY:

I, _____ hereby agree to hold Pam Nelson, DNP, PMHNP-BC, FNP-BC, and her students, volunteers, independent contractors, office co-workers and any other participants ("Releasees") harmless from any and all claims and/or damages (including medical fees and attorney fees) and causes of action of any nature for any and all personal and/or bodily injury or illness, which may occur to myself or anyone else involved in my psychiatric sessions or which may be aggravated or caused by the negligence of others while interacting with CoCo.

ASSUMPTION OF RISK: I, _____individually and/or on behalf of any person accompanying me in my psychiatric sessions, specifically assume any and all known and unknown risk of injury or illness, resulting from interacting with CoCo, which may include, but is not limited to: zoonotic disease transmission, scratching, nibbling, heavy leaning, jumping, light brushing, and/or licking by CoCo, and any unknown or known allergic reaction. I agree to abide by Dr. Nelson's office policies and procedures as they specifically relate to CoCo. If I have any questions as to the conduct that is appropriate when interacting with CoCo, I agree to ask Dr. Nelson before engaging in such conduct. If any injury and/or illness occurs while at Dr. Nelson's office, I, individually, hereby authorize Dr. Nelson to contact the medical professional listed below, or if the medical professional is unavailable or cannot be reached, to call 911 or the nearest hospital. I take full responsibility for my welfare and safety, as well as for any person that I have asked to attend my psychiatric session; and I hereby give permission for emergency medical treatment to be administered as deemed appropriate.

Name, Address, and Phone Number for Medical Professional (or specify "Call 911" if that is your preference):

_____

I, individually, and/or on behalf of anyone accompanying me into my psychiatric session, being informed of the above known risks, and acknowledging other potential unknown risks, have read the above waiver, and release. I understand that by signing this Agreement I, individually, and/or on behalf of anyone that is accompanying me into my psychiatric sessions am waiving certain legal rights.

_____

Client's Printed Name

_____

Client's Signature

_____

Date